North Carolina Industrial Commission

IC File #_____

Emp. Code #_____

Carrier Code #_____

Carrier File #_____

AUTHORIZATION FOR REHABILITATION PROFESSIONAL TO OBTAIN MEDICAL RECORDS OF CURRENT TREATMENT

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employer FEIN _____

Employee's Name	Employer's Name ( ) - Telephone Number
Address	Employer's Address City State Zip
City State Zip	Insurance Carrier
( ) - Home Telephone	( ) - Work Telephone
- - Social Security Number	☐ M ☐ F Sex / / Date of Birth
	Carrier's Address City State Zip
	( ) - Carrier's Telephone Number ( ) - Fax Number

I, _____, the employee-claimant, hereby authorize the
(Please Print)

release of all my medical records of treatment resulting from a work-related injury/occupational disease that occurred/was contracted on _____ to the Rehabilitation
(Please Print)

Professional assigned to me. That Rehabilitation Professional is:

Name: _____

Address: _____

_____

Telephone: _____

_____
Employee's Signature Date

NOTE: THE REFUSAL OF THE CLAIMANT TO SIGN THIS FORM UPON THE REQUEST OF THE REHABILITATION PROFESSIONAL MAY BE DEEMED BY THE INDUSTRIAL COMMISSION TO BE NONCOMPLIANCE WITH REHABILITATION AND MAY RESULT IN THE SUSPENSION OF BENEFITS.

PLEASE MAIL THIS COMPLETED FORM TO THE REHABILITATION PROFESSIONAL NAMED ABOVE.